HIT Standards Committee
Clinical Operations Workgroup
Draft Transcript
April 27, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody, and welcome to the Clinical Operations Workgroup conference call. There will be an opportunity at the end of this call for the public to make comments. Let me do a quick roll call. Jamie Ferguson?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Present.

Judy Sparrow – Office of the National Coordinator – Executive Director
Chris Chute? Martin Harris? Stan Huff? Kevin Hutchinson or David Kates?

David Kates – Prematics, Inc. – Vice President Product Management
Yes, here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David, are you there?

David Kates – Prematics, Inc. – Vice President Product Management
David is here. Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Liz Johnson?

Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
John Klimek? Wes Rishel? Nancy Orvis?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Trudel?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Chris Brancato?

Chris Brancato – Deloitte – Manager, Health Information Technology
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jodi Daniel? Don Bechtel? Joyce Sensmeier? Lisa Carnahan? Marjorie Greenberg?

Marjorie Greenberg – NCHS – Chief, C&PHDS
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Mike Fitzmaurice is on the line. Anybody else on the telephone? With that, I'll turn it over to Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Great. Thank you very much. So for today, just to review the agenda, we have two items on the agenda for today, and then opportunity for public comment. This is scheduled for three hours. I think I'll be surprised if it goes much beyond an hour and a half, just for planning purposes, although we certainly could take the full amount of time if that's necessary.

The first thing and I'm sorry that Betsy and John Halamka are not able to join us here today. Betsy is overseas. The first thing is to discuss the vocabulary taskforce recommendations that we've arrived at as a result of a couple of public hearings and taskforce discussion in terms of governance and some of the infrastructure components of vocabulary subsets and value sets that are going to be required for meaningful use.

The other thing that's on our agenda, and Dr. Fridsma, Doug Fridsma expects to join us at the top of the hour at 3:00 eastern to discuss our next priorities for the clinical operations workgroup, and so those are our two agenda items for this meeting. Is that acceptable to everybody?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Sounds good, Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Let's move on into the first recommendation from the vocabulary taskforce then. So this is the one overriding theme that was very consistent in all of the testimony that we heard from our witnesses, and we've embellished this a little bit with some workgroup discussion and tried to have some nuance to the actual recommendation.

The gist of the recommendation is that there should be a single, central authority with responsibility for coordination of the different value sets and subsets that are required for meaningful use. And so this has been rephrased to some degree to account for the differing authorities that the different owners of some of the vocabularies have, for example. But the primary thrust of this is to have a single, central agency that is responsible for coordinating and, to the extent possible, for actually controlling those things that are required for meaningful use.

And so we talked about a number of processes that would be governed by this entity in terms of identifying what value sets and subsets are needed, who will produce, and who will maintain each value set and subset. And we're referring now to the definition of value sets and subsets that we've used and, I think, have reviewed previously with this workgroup, which is that a value set describes essentially the entire universe of codes or terms that are used for a specified purpose, whereas a subset is a convenience for implementers such as a frequency based subset that is derived from a frequency

distribution of the use of a coding system. The idea in terms of identifying the value sets is not that the central authority would actually perform the identification of the needed value sets, for example, but rather, that it would govern and control the process and the coordination that is needed to establish those things.

The next sub-bullet, determining the appropriate dissemination schedule and update frequency for each set. This is something that we heard loud and clear from our panels in the hearings that there needed to be better coordination for the release of these things, and particularly when they're being required to be used for meaningful use. Then for that particular purpose, if not a unified schedule, a coordinated schedule is absolutely needed by the users and implementers of the electronic health record technology.

The next item, managing the processes for review, testing, approval, and publication of sets, taking the first bullet and actually drilling it down into the specific management processes. Ensuring the existence of a robust, authoritative infrastructure for value sets and subsets, and we'll review the next recommendation also, which essentially is that there should be a central infrastructure capability in or sponsored by the federal government. And then we also thought it was important, and we heard again from our hearing panels that it's important to have education, communications, and outreach with regard to the implementation and use of these value sets and subsets.

Another thing that's been added as the second major bullet under the recommendation has to do with funding. I think that a lot of our witnesses liked and would want to promote what they called the SNOMED model, essentially making sure that licensing is taken care of for the required coding systems. And so that's the gist of what this recommendation, that part of the recommendation is about.

With that overview, what do folks want to discuss about this? Are there any particular items that anybody has a problem with or wants to reinforce or tweak?

Marjorie Greenberg – NCHS – Chief, C&PHDS
I know I'm not a member of this group. I'm a member of the vocabulary taskforce.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Marjorie Greenberg – NCHS – Chief, C&PHDS
So if you want me to wait until others have spoken.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Do you have a proposed change?

Marjorie Greenberg – NCHS – Chief, C&PHDS
Well, I am fine with this slide, and I think it captures what we agreed to or what the consensus was in the vocabulary taskforce. I don't mean to be picky, but when you introduced it verbally, you referred to governed and controlled, and I think those are terms that the group felt – I think they were in the original version, and the group felt really were – they were not. The group was not as comfortable with. Coordination, yes, overseeing that all these things happened, yes. But I think we acknowledged that several of these things wouldn't be able to be controlled by this single entity or even governed solely by—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think, Marjorie, what I said was that to the extent possible, controlled, because certainly we do want to have coordination. We understand that the legal authority of ONC is only for purposes of meaningful use

and doesn't extend to the other purposes. So certainly there's an understanding that those things that are outside the scope of meaningful use can't be controlled in that sense and that coordination is needed. But there is also, I think, a fair degree of a desire to establish better control and that some, I mean, through a coordination function, that's fine. But anyway, I don't know. I'm just rambling on.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Jamie, are we hearing an objection to the wording or the concept?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
If I were to restate, what I think Marjorie is saying is that the other government agencies that have specific responsibilities for some of the coding systems either don't want to or can't be controlled legally by a central authority, but that was actually what our witnesses asked for.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Right.

Marjorie Greenberg – NCHS – Chief, C&PHDS
I have to respond to that, but when you want me to.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Yes. I'd say respond because we want to understand the intent before we respond to you.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Truth in advertising, my agency, the National Center for Health Statistics, is responsible for the international classification of diseases. But I was not speaking just from that perspective. Some of these issues, such as the update, frequency, etc. are decided in law, so it may not be what we would want, but we don't have control over that either. And there are a number. I think what we talked about, and I'm perfectly fine with this language here on this slide, and I guess there were some people who wanted more control or governance. That's for, I guess, this group to decide. But as I understood, and there might be someone else on this call who was on that vocabulary taskforce call.

As I understood that discussion, which I think this reflects that discussion, talking about having this signal agency governing all of this, particularly for a value sets and subsets that go beyond those specifically required by meaningful use, and I think that distinction is made in the next slide. But more broadly, those related to meaningful use and a lot could be covered by what's related to meaningful use. There was not a high comfort level, at least on that call, with keeping the term governance, which is why it was changed to coordinate.

I guess there's a tension here. It could be HL-7. It could be whoever. I think there's a need to make sure that all of this is coordinated and that, at the end of the day, there's not duplication, and we're making these value sets and vocabularies freely available and not in a conflicting way. I think everyone agrees with that.

I think it's just a question of, as I think I put it during that call, going from what we have now to a very distributed process, which is probably too distributed, but a very distributed process, to a control and act process, I think, would be too big a leap. And I think others agreed with me, so that's what we changed this to coordinate. Now coordinate may be not strong enough in some cases, so I don't know.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, and if I could respond to that, if you don't mind. I'll just jump right back in on top of that. I think it's important to differentiate the coding systems, which are, in some cases, controlled by laws, as you said, from the value sets that are controlled and established by the meaningful use regulations that can be controlled. So I think that what we, and maybe this is a point of differentiation that we really should discuss. I think what we're saying should be controlled from the standpoint of release schedules and updates, as well as process controls, and that really is what the hearings were about was governance. It was how to govern the subsets and the value sets that are required for meaningful use. For those things that are, I think, clearly in the legal authority of ONC to control, we want to have those established with a set of parameters that is more convenient for implements and users of the EHRs rather than to maintain things sort of at the convenience of the producers, if you will.

Marjorie Greenberg – NCHS – Chief, C&PHDS
No, and I'm fine with that.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Jamie, this is Nancy Orvis, and I was just going to say, I'd be very happy with … we could say, the span of control for – you know, this slide talks a lot about just the general establishing format from production, dissemination of sets, and sets with sets. It talks only about the sets. It doesn't get to the control and the subsets. And I would say that is definitely what I would like to see a controlled data view or a view to access the subsets necessary to meet meaningful use.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
That is something that I can clarify because the intension on this slide was to say that where we talked about sets, that was intended to mean both value sets and subsets.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Okay. Well, then, maybe that's what you want to put in there.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Yes, Jamie, that's what I read, and I think Nancy's point is well taken, but I read that both would be included.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
That's fine. Let's keep it.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Okay.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Keep it simple.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Yes, I'm on the same page you are, Nancy.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. Marjorie, I want to go back to Marjorie's point because I wasn't intending to say that this central authority for meaningful use should control things that are outside of its scope, meaning things that are established through HIPAA or through other mechanisms. But I think we really were talking about the value sets and subsets that are going to be used by implementers, particularly during the startup of stage one of meaningful use.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Yes. Now there might also be a word, either in the bottom bullet. You might set access to either the vocabulary value sets and subsets, or you could say make vocabulary value sets and access to any subsets required freely available for U.S. wide use. You might be able to say, we want to control or give free access to the – we can look at that as we go through the rest of your slides because I think access is the word that really is what end users are saying. We want a single federal process that we can go to to get these things. I think that was one of the main voices. We want to make sure that somebody has got the handle to give us what we need to meet the law.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
No, that's a great comment. I appreciate that.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Yes. I think it's provide control. So we will provide access to these things in order for entities to meet the rules.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Do you think it would be better in that very first adopt point to say required by meaningful use? Then I think there's less of a debate.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I do think the intent and the consensus of the taskforce was that it should be everything related to meaningful use, recognizing that it's not possible to do that for everything that's related.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Right, and some of the criteria wouldn't apply. I mean, I don't think you can say required, Marjorie, because of that very issue. It depends on which one you're picking … criteria.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Well, and there's also the problem that not everything can be required in rulemaking.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I don't think required is ever a good word in this stuff.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Well, it does say required down there.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Yes, the last bullet is where the required word appears.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. The intent there was to say if something is required for meaningful use, then it should be licensed.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
And it should be free.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Marjorie Greenberg – NCHS – Chief, C&PHDS
That's okay there, I think.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Yes.

Marjorie Greenberg – NCHS – Chief, C&PHDS
…top….

Chris Brancato – Deloitte – Manager, Health Information Technology
I think you need to put just a finer point on free, free to use.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
So it's clear it's without cost?

Chris Brancato – Deloitte – Manager, Health Information Technology
Correct.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
It's not just ease of access. It's actually it doesn't cost anything.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Well, doesn't freely available say that?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
That's the intent.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Yes.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Because otherwise you'd say easily available. Freely tells me no cost.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes, I don't think that's quite clear enough.

Chris Brancato – Deloitte – Manager, Health Information Technology
Yes. No, I think it's….

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I think it's better to say no cost.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Available for U.S. wide use at no cost.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Yes, that's very clear.

Chris Brancato – Deloitte – Manager, Health Information Technology
Yes, I agree.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
By the way, this is Stan Huff. I've been listening since the start, but it took a while to get connected from Copenhagen.

Joyce Sensmeier – HIMSS – VP of Informatics
Jamie, this Joyce Sensmeier joined as well.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Hello, Joyce.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
Since we're identifying, this is Don Bechtel. I also joined.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Hello, Don. What other comments or discussion points do we want to have in terms of this slide for recommendation one? I do have a note to add the term "access" in here. I'm not sure exactly the right way to do that, but I will add that.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I think it looks pretty good.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I do too, and I think it's – one would ask. Do we think we can this … great recommendation.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Well then, let's go on to the second one, and our intent in establishing these hearings with the vocabulary taskforce was to explore issues of governance first, to establish rules of the road or at least a process for establishing rules of the road with regard to those things that were particularly required for meaningful use, but also other things related to meaningful use. And then our intent was to next dive into infrastructure and tooling that's going to be required by implementers of these standards. And that is still our plan, but even in our first two public hearings, we did hear a lot of testimony about the need for authoritative infrastructure to be established right up front.

And so we thought it was important to add this recommendation to the discussion in the standards committee that we'll have tomorrow for forwarding on to Dr. Blumenthal. And before I go through and read the actual recommendation, for those who were not able to attend our public hearings, what I would say is that there was not unanimity of opinion on the approach to establishing infrastructure. But there was unanimity on the need to establish an infrastructure. What I mean by that is, I would say that I think over half of our panelists and witnesses requested basically a single place to go that would be the authoritative repository as a single, centralized, integrated repository that had all the vocabularies, all the

value sets, all the subsets, anything that needs to be used for meaningful use, that they would have one place to go in a single, physical infrastructure.

But there was also, I think, a significant minority of the witnesses who said that a centralized infrastructure, a single central repository is the wrong way to go. That distributed repositories in the private sector should be enabled, and that essentially you should just have a system of pointers to go to the places where the artifacts can be located. I think then in our subsequent taskforce discussion on that point, I think there was some discussion of the experience that we had with HITSP standards, as an example of sort of the pointer approach of saying go here for this; go there for that. And that's not necessarily working so well for the users and for the implementers in all cases. But at the same time, we wanted to respect the fact that there may be decentralized alternatives. There may be alternative private sector solutions that could be very valuable.

We established that diversity of opinion in this recommendation, and what we're saying here is that we do need to have authoritative infrastructure established particularly for the value sets and subsets that are related to meaningful use, and the intent is to establish one stop shopping for meaningful use vocabularies, but to do that through alternative mechanisms. One mechanism is to establish a central repository, a central download capability, and central feedback loop mechanism in the federal government, in some government agency or office that would be used for dissemination of the meaningful use vocabulary artifacts. At the same time, we recommend establishing a decentralized mechanism for private sector alternative distributed repositories that may be potentially modular or complete repositories that could include alternative distribution mechanisms that may work for different users and implementers, may work on alternative schedules, but that would use federally standardized exchange formats for the dissemination of the vocabulary artifacts.

Another thing that was referred to on our previous recommendation is we wanted to differentiate the specific value sets that are required for meaningful use such as, in fact, our primary discussion was about the quality measure value sets that are required for calculation of the numerators and denominators for those particular measures where we needed to, or we wanted to recommend, that those should be tightly controlled. That they should be on a single integrated schedule, preferably the same schedule for all of those artifacts from an authoritative source. But then, at the same time, we heard a variety of different opinions, some saying it was extremely important to have different subsets, whether medical specialty based subsets or frequency of use based subsets of the vocabularies to be available. And some folks felt that particularly the medical specialty based subsets were not particularly valuable. Fine, they don't want to be required to use those.

But the idea that also going back to the implementation workgroup hearings that the standards committee has been holding, we heard some of the same things here about the need for starter sets. So in order to get up and running in the initial implementation of an EHR that uses these controlled vocabularies, you need a starting place. You need to have the subsets made available to you, and have the ability to choose which subsets work best for you, and so that's really what that was aimed at.

Another thing that we heard as a significant minority view was the need for a tooling that would make vocabularies searchable and discoverable. And so rather than get into specifics about what features and functionality that would entail, we recommend establishing an open process to standardize those things that will also be made available to implementers of EHR technology under the meaningful use set of rules, under the meaningful use program, that would make the vocabularies searchable and discoverable for the users, for the end users at the other end of the EHR pipe, if you will. So that's the second recommendation, and I'd love to get comments and discussion on this.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
On the last bullet, the searchable consensus base, searchable tooling for vocabularies, and I brought up under my testimony when I talked to the terminology folks about still having some developers, I keep seeing some documentation coming up from a couple of people saying we want to leverage the UMLS CD and work on stuff, and both Betsy and Sue Nelson laughed when I said that because you understand the issue of searchable. Some people are thinking that if UMLS is available that that's one kind of end user searchability. But we know that that still shows a one term to many, many other things, and is meant for research, and is not meant for—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
It's not meant for clinical documentation purposes generally.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
And you don't have to put, like, and not UMLS, but you need—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
No, I mean, that's why I said we're not making a specific recommendation about what that is, but we're recommending that there needs to be an open, public, consensus-based process to establish the parameters of tooling that will be made available for the end users of the EHRs really primarily for clinical documentation purposes.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Right, so it could be said, making it for those kinds of end users rather than the traditional tools used to help researchers.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Something like that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
You just said it …. Or really just tacking onto the end of that last bullet, for EHR end-users.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Excellent.

Joyce Sensmeier – HIMSS – VP of Informatics
Another thought on there, when you talked about that, you used the word parameters, which gives me a different feel than aspects. This almost made me think that this group was going to standardize the tooling, and I don't think that's what you mean. It's standardizing the parameters and how to get at the tooling and that kind of thing, correct?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That's correct.

Joyce Sensmeier – HIMSS – VP of Informatics
Just maybe some tweaking of the language there to clarify that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
So parameters instead of aspects.

Joyce Sensmeier – HIMSS – VP of Informatics
That's one suggestion. I don't know if that's the best one.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I like it.

Joyce Sensmeier – HIMSS – VP of Informatics
Okay.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Does the second dot point preclude alternative repositories in the public sector?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
No. I mean, that wasn't the intent there. That really was, I think, trying to merge together two different parts of the recommendation, one of which was to enable private sector alternatives, and another was to enable decentralized alternatives.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Right, but by mentioning just the private sector, it could be interpreted, I guess, that way.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Decentralized private or public sector, okay.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Thank you.

Joyce Sensmeier – HIMSS – VP of Informatics
Jamie, the other comment I had is on the first bullet, but we don't have to go there unless others are ready or you're ready to do that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Go ahead, Joyce.

Joyce Sensmeier – HIMSS – VP of Informatics
To me, in order to have that occur, you will have to achieve the recommendation on the previous page at the bottom. It assumes that you will have a freely available at no cost ability to get at this. Am I missing the boat on that or is that true?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think those things could go hand-in-hand. I'm not sure if a central download capability, for example. I mean, I can imagine ways that that would work with separate licensing, so you'd enter a license number or something to get your download.

Joyce Sensmeier – HIMSS – VP of Informatics
That's true. I was just trying to sort through the different models that there are, and it could be pretty complex.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. But, no, I don't think it actually requires the sort of national licensing.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes, you could imagine that there could be still terminologies, and it would be just like the UMLS medi-thesaurus. Even though the terms are included, and you can download them, there's a statement that says, but you understand you still need to be licensed to use this one from whoever holds the license.

Joyce Sensmeier – HIMSS – VP of Informatics
Right. That's a good example, and I think when HITSP was thinking about not using the pointer system, all of these factors were just kind of more than we could deal with at that point in time, but not that they're not surmountable. I think it's great to consider that, and it would be great if it could happen. But it's just not simple.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Joyce, I think that … as you're thinking about that, does that go back to recommendation one? So, we're asking for it to be not required?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
No, I want them to all be free.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Right. I understand.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
It's just not essential.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Okay.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
If for some reason we couldn't achieve that, why I still think we would still go forward with this.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Because it still would be an improvement over what we have today.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Absolutely.

Joyce Sensmeier – HIMSS – VP of Informatics
Yes, I do agree.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. There was also a fair bit of discussion and some tension between both taskforce members and also panelists whose stakeholder representation was either the producer of value sets or the consumer of value sets. And what I mean by that is generally more of the producers of the value sets and subsets were more likely to recommend decentralized alternatives, whereas I think that the actual users and implementers of the EHRs, the provider panelists, witnesses, and taskforce members who are actually implementing the EHRs for clinical use, I think, were absolutely unanimous in wanting to have a central, physical repository where they could go to one place and actually get everything.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes. It was pointed out, there could be some – yes. There are some mechanisms whereby you could accomplish the download, but it wouldn't physically be in the same place, but it would take more work.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. But it would still be one place to go. And you go to one place, and then you've got a pointer to another place, and then links need to be maintained and things like that.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes.

Joyce Sensmeier – HIMSS – VP of Informatics
Yes. I think the user's perspective is so important here. The whole purpose of this is implementation, so it is a naughty problem, but if this effort can't solve that naughty problem, I don't know who can.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, but let me sort of take the contrary view then. If that makes it more difficult for the producers, and I'll take NQF as an example; they're herding cats already in terms of all the different measure stewards that they have, and they would have to have probably significantly more resources, funding, or something if they were going to try to corral that into more of a centralized format. So there may be higher costs of doing that, and where's the money going to come from.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
That's probably a good point, Jamie. I think the challenge would be, I don't know the funding source, but I think the cost is lower at that place than it is disseminating across a whole nation. Now that doesn't solve the problem. In other words, if we all have to do it separately, that's going to cost more than having them do it, but you're right. They have no funding to do it, I presume.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I think, not at present, no.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Right.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes, there's more than one situation to think about, and I'm not sure I've thought through all of them, but in … for instance, I mean, Clem was one of those who was pretty vocal, and I'm not sure we got to the bottom of exactly what he was thinking. But it seems to me that the work wouldn't necessary accrue to the LOINC committee. What it would be is that whoever this agency was that's doing this work would grab what was already available from LOINC, and if it needed to be reformatted so it was downloadable or whatever, that would be work that would be done after it had been posted by the LOINC committee.

So we weren't trying to create new obligations for the producers, but anyway, because if you didn't change anything, it would be, yes, everybody who uses the terminology would have to go through the work of figuring out how to download the file in that format and import it into a standard format, and that's what we're trying to do once and save everybody who uses it the work of doing all of that each time at every facility.

Joyce Sensmeier – HIMSS – VP of Informatics
Exactly.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Again, I like this with the couple of wording corrections that have already been suggested.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Does anybody else have anything else on this recommendation two?

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
Just one thought. You have espoused the principle that the government should make these vocabularies freely available to all who are using them for meaningful use purposes, if I understood that. But it's not just the vocabularies. It's also the combinations of the vocabularies to produce, let's say, a quality measure or a performance measure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Exactly. In fact, it's particularly those value sets that may be combinations of the different things.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
And somebody may own those particular quality measures, and so that you might consider the principle that the quality measures ought to be able to be configured for free, as well as to have the vocabularies available for free.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay. Yes, so what we're saying is and what we had discussed that I thought we were saying in this recommendation one was that essentially the value sets that would be those combinations of the vocabulary terms and concepts required for a particular measure should be free.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
Okay. Now maybe this is something that the policy committee needs to consider, not the standards committee, that you might have to pay a quarter every time you use a quality measure, even if the vocabularies are free.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
We can certainly bring that up, I think, in our discussion tomorrow as well. Then what I'd like to do is let's switch to the next slide to the questions. There were a couple of themes that came up that we said, well, we'll deal with those later kind of thing in the taskforce. The first one is that we really did try to focus the scope of this governance discussion on the value sets that are required for quality measures and other purposes, as well as the subsets, the convenience subsets, including those starter sets to enable the initial implementation of EHRs for those who were just starting out with these systems.

But we did branch out. And, in fact, in this conversation earlier, some of the discussion was not about the particular value sets and subsets, but even about the base standards, the entire vocabularies. And so, one of the questions then that we wanted to discuss with the standards committee tomorrow was the

question of whether the scope of the recommendations should include the base standards, and I think, recognizing back to the point that Marjorie was making earlier that some of these things are established in law. Therefore, can't be controlled under meaningful use regulations. But even so, in that case, perhaps there could be some sort of improved coordination function. And so how do folks feel about that question, and are there particular points that you would want brought up in the standards committee discussion tomorrow about that?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Again, I would voice the opinion that, again, with the recognition that Marjorie has brought up that we don't control the timeframe of production of the standard terminologies. I would still like to see the terminologies, the full terminologies that are the source for the value sets be available for download from one central site.

Joyce Sensmeier – HIMSS – VP of Informatics
I think we're actually moving. I mean, there's been a kind of recommendation about that on the books for some time in the UMLS, by including them all in the UMLS. The question, I guess, is if, through their inclusion in the UMLS, they really are in the format that everybody needs, or whether you have something else in mind. I think, as long as the recognition of alternative distributions, as we talked about in the previous slide, having them all available from a single place is, I can appreciate that that—

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Still a good idea.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
Jamie, if I could be a little self-serving for a second, USHIK, the U.S. Health Information Knowledge Base, is a metadata registry. Actually, it's many registries pulled together. It did this for the HITSP data elements. As of July 15th, we had all the data elements mapped to all of the HITSP documents, I mean all the HITSP documents, and now we're trying to do the same thing for capabilities and service collaborations. I would say we're halfway there.

We're also working with X12 to have the standard developing organization be responsible for the maintenance of their data in USHIK. Now this isn't everything that you want or that you require in this central authority, but I would guess that we're maybe halfway there, and it's something that should be considered.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. And so I think actually that's a good lead in to the discussion about the next steps for the vocabulary taskforce because our intension still is to look at infrastructure and tooling recommendations as our next set of public hearings. So I think that's where we would get to explore that in more detail, Mike.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
I would also refer people to text … note 903 of HITSP where we put in a lot of the guiding principles for metadata registries in healthcare.

Joyce Sensmeier – HIMSS – VP of Informatics
Mike, are you putting whole vocabularies into the knowledge base?

Michael Fitzmaurice – AHRQ – Co-Chair IXIT

No, we're not a vocabulary service. We're putting in just the data element set, say the value set required for a particular purpose, let's say, for a use case.

Joyce Sensmeier – HIMSS – VP of Informatics
Right. Okay. That's really what we were talking about before. It would be an alternative for that.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
The metadata registry can't really hold vocabulary sets.

Joyce Sensmeier – HIMSS – VP of Informatics
I didn't think so, and that's why I guessed we were talking about the whole vocabulary, so I got a little confused.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
Yes, and I wouldn't want to bear the expense or infringe upon the intellectual property of the standard developing organizations or … organizations. I just want to have some place for what the government requires. Here's an easy way to get at it. Then point to some place like UMLS or to CDC or National Cancer Institute for their vocabulary services. I've talked with Betsy and I've talked with Ken Buetow about this.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Again, I think you're saying something different than what I'm asking for, Mike. I think, at least right now, I would say my needs are not met by just having everything incorporated into UMLS because it's not easy to use it back out of there.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
Okay.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
But secondly, again, I would just as soon go to one place and download it. I don't want just a link that says go to this Web site, and here, download LOINC in its format. Download SNOMED in its format. Download CPT-4 codes in its format. That's just leaving me a whole bunch of work to do that's going to be done over and over again in different facilities, figuring out how to do that. And I would much rather see those, basically have the government make an agreement that their terminologies can be distributed from this site and work through the details once of how we communicate from the producers and mount the next version on the site. But there's one place for everybody to go to get it.

Michael Fitzmaurice – AHRQ – Co-Chair IXIT
I fully agree with you, Stan.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Okay.

Joyce Sensmeier – HIMSS – VP of Informatics
There is an example in the church music-publishing world. I know you'll probably think I'm crazy to talk about that, but it's called OneLicense, and it is a one-stop-shop for getting music licenses from any of the hymn notes or … that are available out there, so all of the organizations agree to use that process or the entity, and then they get paid by the licenses that are purchased through it, so an interesting correlation maybe.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes, that is.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
No, I think it's actually exactly what we want.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Let me move on to the last question on slide four there, and that is that we did hear about what ONC's authority is in this regard, and this goes back again to some of the same questions, but that the authority of ONC is limited to those things that are directly related to meaningful use regulations. But a lot of the stakeholder input that we received through these public hearings really talked about a broader scope for anything that's potentially related. And so, but that could involve things that are actually controlled in completely different entities, whether it's NCI or some other kind of entity that has a different mission, a different charter, different legal authority and so forth. And so I think the general question that we wanted to essentially double check and raise with the committee is is there some other approach? Because essentially what we're saying is this is the best we can think of, but is there a better idea for how to coordinate this that would achieve that broader goal perhaps better while also meeting the meaningful use needs for 2011?

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes. I think the bigger thing is highly desirable, but unless I'm – to have the scope and reach that I would hope it would, it would require legislation, which we might want to bring up, but I wouldn't want to not do what we can accomplish through ONC, waiting for or hoping for legislation. I mean, to be very candid, what I would like to see is that the terminology that we're using for clinical trials or that we use for reporting of adverse events within the FDA or for coordination between medical records that we're exchanging with the VA or DoD, the whole scope of medical care and clinical research would in fact end up being coordinated in the way that we've described. But once you're talking about the DoD, the VA, and the FDA, all of which have regulatory and legislative mandates already, I don't see how you could bring those under a single umbrella without new legislation that did that intentionally. But I would view it as a very positive thing.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Maybe, Jamie, what you suggested is a phased approach to begin with that we are going to tackle meaningful use, and like Stan said, obviously if legislation is required, that takes time. That we don't take it off the radar, but we focus on the immediate need. Is that a potential?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. No, that's sounds great. Essentially, the scope of authority that we have in the taskforce really derives from the standards committee, and so it's not global across everything that's going on in the country.

Chris Brancato – Deloitte – Manager, Health Information Technology
I want to bring up a conversation Doug and I had after the last meeting when we talked about this very thing about what is ONC's statutory authority or not. I think we need to recognize that there's an interpretive body that happens legally within HHS or even within the federal government that derives interpretations of what ONC statutory authority is or isn't. So I only mention that to recognize that we're making a layman's interpretation of what we think that ONC's statutory authority is.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right.

Chris Brancato – Deloitte – Manager, Health Information Technology
And there may be an additional legal definition that would override that interpretation.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
No, that's right, and I was just talking about our understanding in the taskforce, which is that kind of informal understanding that I think you're talking about.

Chris Brancato – Deloitte – Manager, Health Information Technology
Sure. Thanks.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I get it.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Maybe we're saying this is a great aspiration, and we don't want to take it off the radar, but it's not something we can do immediately.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. But we're sure as heck hoping that ONC actually does have the statutory authority to do this for those things where they're promulgating the regulations.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Absolutely. It'll be interesting to see what Jodi Daniel has to say about this. Has she seen this stuff, Jamie?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, she has. I've sent it to her.

Marjorie Greenberg – NCHS – Chief, C&PHDS
Good. Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

Judy Sparrow – Office of the National Coordinator – Executive Director
Is Doug on the line, do you know? Doug Fridsma, are you there?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
He did have another meeting until 3:00, so we should probably give him a few minutes.

Judy Sparrow – Office of the National Coordinator – Executive Director
I'm just going to run down the hall and see if I can round him up.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
All right. In the meantime, let me just first double check. Is there anything else on the vocabulary taskforce recommendations that hasn't already been said or discussed that anybody wants to bring up

before we go into the same conversation with the broader standards committee tomorrow? Okay. Good. Thank you.

The general topic that we wanted to have Dr. Fridsma on the line for is to talk about what's next. What are the immediate next steps for this group for the clinical operations workgroup, aside from the vocabulary taskforce? We do have some next steps that we talked about, for example, starting with infrastructure and tooling for the vocabulary taskforce. But for the broader clinical operations workgroup, I mean, I think the gist of it is that we made our set of recommendations for stage one meaningful use for what the interoperability, data exchange, content exchange, and vocabulary terminology standards are for stage one. I think, now, we're really, frankly, waiting for there to be some new objectives, some new meaningful use ideas, some new, specific measures that need to have standards to accomplish them in order to move forward with the next body of work for the clinical operations workgroup.

And so, rather than sort of makeup work for ourselves, what I was going to recommend to the workgroup members is that we essentially put ourselves on hiatus until there's some new subject area or some new material for us to deliberate about and make any standards recommendations on. So I'd love to hear from anyone else on the phone who has other ideas about what's next for the clinical operations workgroup.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes. I'm pretty comfortable with what we've taken on in the vocabulary area. Yes, I can't think of—

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Yes, I think we're all waiting for the standards and then, of course, stage two.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. So until we get the final rule and until we get more from the policy committee, I was going to recommend that we unschedule the next couple of meetings that we have and then see where we go from there, and essentially go on hiatus.

Judy Sparrow – Office of the National Coordinator – Executive Director
Does that include your hearing schedule, Jamie?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Now I think that there are a couple of things. One is that we want to continue moving forward with the vocabulary taskforce, as opposed to the clinical operations workgroup. Those meetings, we would want to continue. We also discussed, last time we met, we talked about claim attachments as a potential hearing. And, in some discussions with CMS, I think we've decided not to do that in the very near term, and so we'll certainly have plenty of opportunities to talk about that. I have been kind of in the background talking to the relevant standards bodies about their work in the attachments area, and that's probably something that we can do, either over the summertime or in the autumn, but I don't think that's terribly urgent. Now if anybody feels differently, let me know, please.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Jamie, the one question I have is the clinical attachments group at HL-7, which is still meeting because it is X12, and I pay money every year to keep having these people go. They went to Las Vegas instead of – since the international meeting of HL-7 is not going to do this. I think we should have some recommendation on whether clinical attachments goes away or becomes part of clinical documents, you know, eventual evolution of CDAs or something. You're just saying that we won't look at that until next fiscal year or what?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Well, I don't want to say next fiscal year, but we had talked about having sort of a hurry up hearing, if you will, and put something together real quick. I think that a more deliberative approach is what I would recommend, and so I think whether it's over the summer or maybe in September, something that enables people to think through issues after they see what the final rule is for the first round of meaningful use standards. Then I think people need to digest that, be able to react to that, and come up with their claim attachments or their clinical attachments testimony points and positions in reaction to the meaningful use final rule. That was—

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Let me ask. Are the same individuals involved or not, because the insurance plans are the ones that primarily sit on that group?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right. There are certainly a number of insurance companies, but there are also some innovations coming in.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Mayo is involved.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Right, so Mayo has implemented this, along with Arizona Medicaid. But there are also some innovators, I would say, who are coming up with some new ideas, based on their experience in this area about where these attachments might go in their next phase of development. I think we'd want to certainly hear from them in this kind of a panel. Again, I also think it's important to hear that in the context of meaningful use.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
All right. That's fine. As the TriCare Health Plan, I have been paying to have people go to these committees for six years, and there's no rule out.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
I'm telling you because I would love to use those people, that money to do some other things on standards.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
I'm, frankly, because of the DSMO thing as a government entity, I would also like to get. We could use that money, and I could use those people to do other things, so I do wish. I definitely have three subcontractors that I'd like to have come to that hearing: Health Net, PGBA of South Carolina, and Wisconsin Services, whatever it is.

Joyce Sensmeier – HIMSS – VP of Informatics
WPS?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
WPS.

Joyce Sensmeier – HIMSS – VP of Informatics
Yes, and they participate in that group.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
I know they do. I pay them to go there.

Joyce Sensmeier – HIMSS – VP of Informatics
That's on your dime too.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
That's exactly what I'm saying. I have three people, three that represent the TriCare Health Plan, and I would like to have their honest opinion on what they think we're accomplishing at this point.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics
I just wanted to let you know that I'm on the phone. Sorry I was a little late coming in.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Great. Thanks. Doug, we were talking about next steps for the clinical operations workgroup, and I had put out a recommendation that we essentially go on hiatus until after we get the meaningful use final rule or get some additional direction from the policy committee. One of the things that had been sort of one of the loose ends that had been left dangling was the idea of a hearing on attachments and the potential role that the attachments in its relationship to meaningful use. That's the discussion that we're in right now.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics
Okay. I think the discussion or the comment that you made with regard to meaningful use and the like, I think, is an important one. We haven't really gotten a lot of direction from the policy committee with regard to some of these questions. I think one thing that we need is a process or a way to get some of these concerns raised to that committee to help provide some guidance on the kinds of things that we should be working on and the priorities that we should tackle.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
I think one of the key things is part of this HIPAA law requires participation in dual standards organizations like on clinical attachments. If the government is not going to put out a rule on clinical attachments, then they need to do something because we could certainly use that money, and I'm not the only agency that does this. I mean, I would have loved to be putting these on other things if we're not going to implement a rule for clinical attachments. Change it. So I'm just—

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics
Nancy, I understand the concern. The question would be where would we have that question answered for you?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
I don't know if it's through the federal advisory taskforce or whether you say it's through the whole – jeez. I don't know if WEDI. I mean, there are lots and lots of health plans that are making commitments like Mayo to participate in these standards groups for six years on clinical attachments.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services

Could I add something?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Please.

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
Just to clarify a little bit, what the statute tells us is that we need to adopt the standard by 2014 to be implemented in 2016. So there's an obvious notion there that this queues in behind a number of other things, so that that in itself kind of affects timing and workload and resources.

The other thing that we wanted to discuss here is not so much is there going to be a regulation, and is there going to be a claims attachment, but this thought of is the direction that the standards organizations have been following for the past number of years still the right way to do this if you turn around and look at this new environment with potentially health information exchanges, more robust electronic health records. How does the notion of a claims attachment slot into that environment? That's what we were thinking about doing.

It's not a question of is there going to be a regulation. We're told to adopt something. But the question is, what does it make sense for a claims attachment to be in this day and age?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Karen, actually, the direction I'd like to see is how could you sunset that stuff and then have it be put into a new direction in some format so that it gets out of the strictly, I mean, a clinical document. Claims attachments are just a special use of a clinical document. But it would be good to think about where can we discuss something like that.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I just want to say that this basic idea of moving the claim attachment to a special purpose or an alternative purpose for the same clinical documents that are exchanged in meaningful use is something that's been discussed a few times in the standards committee, and I think that's why it's on our agenda for discussion here now.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes. I guess I would ask Karen, I mean, what do you think we could do useful to help you in that regard? Would you like to have some public hearings that explored whether people want to keep going in the same direction or whether they want to kind of open the book again and rethink the approach? Would that be useful, or do you want to do some sort of discussion inside first before you would want to have public hearings like that occur?

Karen Trudel – CMS – Deputy Director, Office E-Health Standards & Services
I don't know, Stan. Either way, but the question that you phrased is exactly the one that we're looking to get the broad input on, which is do a majority of industry folks think that this is still the same way to march? And I think the concern that we originally had was that we started thinking about this as though we had to resolve it right away, and we really don't. So the question is the timing and how to do it in a way that gives people a chance to really think through some of the implications as opposed to rush to have a hearing, which was what we had initially thought of.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Yes. If I could throw out another context point for this discussion though, I think that some of the specifications that are currently under development in the NHIN are for the purpose of sending clinical

documentation to payers, and that's an immediate sort of development. And so it seems to me that there is the opportunity for getting input from that quarter on this question as well. And I think that goes exactly to your question, Karen, about whether the previous direction is the right direction, or maybe this is—

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
I think that's exactly right. You could think now that it might be a much more service oriented approach than a messaging approach that you might want to institute here.

Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.
It's Don Bechtel, and I'm thinking that there's no reason why NHIN cannot use claim attachments as they're currently specified with X12 and HL-7 today in a trial basis, and let's determine in a more practical way whether this is the best way to go or not, to answer Karen's question. Treat it more or less as a pilot opportunity to exchange documents using that methodology. And if it's not practical, then we should look for something else. But they don't have to be adopted under HIPAA for us to use them. They're there now and ready to be used.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
I'll tell you what I'm thinking from this conversation is that we may want to have – I'm going to say, in general, I still want to propose that we go on hiatus as a workgroup until we get both more input from the policy committee or until there's an interpretation of our recommendations that comes out in the final rule for meaningful use that we then want to discuss and react to. I guess the exception to going on hiatus is I would recommend that, over the course of the next couple of months, we might have a couple of phone calls to discuss these issues around attachments in preparation for a hearing some time later this year. How does that sound to folks as a general direction for the workgroup?

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
I would second that. This is Nancy.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes, I like that. This is Stan.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Anybody feel differently about that recommendation? Okay. So, Judy, what I'm going to request then is that we go ahead and schedule, I'm going to say, let's schedule one call about a month from now and another one about a month after that for a couple hours, each one. And, other than that, I think that the rest of the meetings scheduled for this workgroup, we can cancel for now.

Judy Sparrow – Office of the National Coordinator – Executive Director
Right. Okay. I don't think I actually have any on the books quite yet, so that's serendipitous.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Okay.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Is there anything else that workgroup members want to bring up on this call? If not, then we can move on to the public comment. Judy, I think we're ready to take public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Operator, let's see if we have anybody from the public who cares to make a comment, please.

Operator
We have no comment at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you. Thank you, Jamie.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer
Yes. Thanks, Jamie.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Good call, everybody. You get a little time back.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thanks, Jamie. See you tomorrow.

Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief
Thanks. Bye.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy
Thank you. Bye-bye.